MetLife®

Group Life Claims
Telephone Number: 1-800-638-6423

Metropolitan Life Insurance Company
Claimant's Affidavit

Group Life Insurance Plan of _____ Group Policy No. _____

Insured's Name _____ Insured's Social Security No. _____

Note: This Affidavit may be completed by any of the surviving relatives listed below or by the duly appointed estate representative (the "Claimant"). The Claimant must complete all Parts of this Affidavit. If this Affidavit is being completed by a legal guardian on behalf of a minor child, please attach the certificate of authority or other document appointing the Guardian. If this Affidavit is being completed by the estate representative, please attach the certificate of appointment or other document appointing the estate representative. This Affidavit is intended to enable MetLife to make payment in accordance with the beneficiary provision of the Plan. This Affidavit must be signed by the Claimant and sworn to before a notary public.

State of _____)
) ss:
County of _____)

I, _____, being duly sworn, state that, to the best of my knowledge, the following statements are true:

Part A: Information About the Claimant

1. Your Name _____
2. Your Address _____
3. Your Relationship to the Insured _____
4. Your Social Security Number _____
5. Your Date of Birth _____

Part B: Information About the Insured

1. How many times was the insured married? _____

Names of All Spouses	How Was Marriage Terminated?	Date of Termination
_____	☐ Death ☐ Divorce ☐ Annulment	_____
_____	☐ Death ☐ Divorce ☐ Annulment	_____
_____	☐ Death ☐ Divorce ☐ Annulment	_____

2. Was the insured survived by any natural children or legally adopted children?
☐ Yes ☐ No If Yes, how many? _____

3. Was the insured survived by a parent or parents? ☐ Yes ☐ No

4. Was the insured survived by a sibling or siblings? ☐ Yes ☐ No

Part C. Information About the Insured's Widow or Widower

1. Name of Widow(er) _____

2. Widow(er)'s Social Security Number _____ (if known)

3. Widow(er)'s Date of Birth _____

4. Date of Marriage to Insured _____

Part D: Information About ALL the Insured's Natural Children and Legally Adopted Children. If you are a surviving child, please include yourself on the list below.

Name of Child	SSN (if known)	Date of Birth	Address or Date of Death, if applicable

Part E: Information About the Insured's Parents

Name of Parent	SSN (if known)	Date of Birth	Address or Date of Death, if applicable

Part F: Information About ALL Siblings (Sisters, Brothers) of the Insured

Name of Sibling	SSN (if known)	Date of Birth	Address or Date of Death, if applicable

Part G: Information About the Insured's Estate

1. Has a court issued, or is expected to issue, a document appointing an executor or administrator of the decedent's estate?

   ☐ Yes ☐ No

2. If no, I certify that there has not been nor is there expected to be any executor or administrator or other representative appointed for the insured's estate.

The information I have provided herein is true, correct and complete to the best of my knowledge. I understand that payment of the Plan proceeds will be based on the information I have supplied herein.

I also understand and agree that payment of the proceeds of the insured's group life insurance coverage under the Plan will be issued either to myself in full, distributed amongst the surviving relatives of the insured, or paid to the insured's estate, in accordance with the terms of the Plan. If there are no surviving relatives of the insured, payment will be made to the insured's estate. If no estate has been or will be opened, payment cannot be made. I further release MetLife, the Employer and the Plan from any further liability in consideration of such payment.

Claimant's Signature _____

Sworn to and subscribed before me this _____ day of _____ in the year _____

Notary Public _____

My Commission Expires _____